

Dermatology Prescription Referral Form

A-O



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PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: _____ Last Name: _____ Date of Birth: _____ M F
 Street Address: _____ City: _____ State: _____ Zip: _____
 Cell Phone: _____ SSN: _____ Patient Preferred Language: English Spanish _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
 Address: _____
 Phone Number: _____ Fax Number: _____ Contact Person: _____
 Office's Preferred Method of Contact: Phone Fax Portal Email: _____ Other: _____

PATIENT CLINICAL INFORMATION / HISTORY - PLEASE FORWARD CHART NOTES AND RELEVANT LABS

Diagnosis: _____ ICD 10: _____ Weight: _____ Height: _____ Tb Test Results: _____
 Drug Allergies: _____ BSA%: _____
 Previous / Failed Medications: _____

PRESCRIBING INFORMATION

NEW RESTART CONTINUING | SHIPPING PREFERENCE: Deliver medication to patient Deliver medication to MD

MEDICATION	DOSAGE	SIG	QTY	REFILLS
<input type="checkbox"/> CIBINQO	<input type="checkbox"/> 100mg Tablet <input type="checkbox"/> 50mg Tablet <input type="checkbox"/> 200mg Tablet	<input type="checkbox"/> Take _____ mg by mouth once daily		
<input type="checkbox"/> CIMZIA	<input type="checkbox"/> 200mg/mL Starter Kit <input type="checkbox"/> 200mg/mL PFS Weight: _____	<input type="checkbox"/> <u>Induction Dose</u> (if ≤90kg): Inject 400mg SC on week 0, at weeks 2 and week 4. <input type="checkbox"/> <u>Maintenance Dose</u> : Inject _____ mg SC every other week	3	0
<input type="checkbox"/> COSENTYX	<input type="checkbox"/> 150mg/mL PFS <input type="checkbox"/> 150mg/mL Sensoready	<input type="checkbox"/> <u>Induction Dose</u> : Inject 300mg SC on weeks 0, 1, 2, 3, and 4. <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 300mg SC every 4 weeks	10	0
<input type="checkbox"/> DUPIXENT	<input type="checkbox"/> 300mg/2mL PFS <input type="checkbox"/> 300mg/2mL Pen <input type="checkbox"/> 200mg/1.14mL PFS	<input type="checkbox"/> <u>Induction Dose</u> : Inject 600mg SC on day 1 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 300mg SC every 2 weeks thereafter <input type="checkbox"/> <u>Induction Dose</u> : Inject 400mg SC on day 1 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 200mg SC every 2 weeks thereafter	4	0
<input type="checkbox"/> ENBREL	<input type="checkbox"/> 50mg Mini <input type="checkbox"/> 50mg/mL PFS <input type="checkbox"/> 50mg/mL SureClick	<input type="checkbox"/> <u>Induction Dose (Psoriasis)</u> : Inject 50mg SC twice weekly for 12 weeks <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 50mg SC once weekly	8	2
<input type="checkbox"/> HUMIRA	<input type="checkbox"/> Psoriasis Starter Kit <input type="checkbox"/> 40mg/0.4mL PFS <input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> HS Starter Kit <input type="checkbox"/> 40mg/0.4mL PFS <input type="checkbox"/> 40mg/0.4mL Pen <input type="checkbox"/> 80mg/0.8mL PFS <input type="checkbox"/> 80mg/0.8mL Pen	<input type="checkbox"/> <u>Induction Dose</u> : Inject 80mg SC on day 1, then inject 40mg SC on day 8, and inject 40mg SC on day 22 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 40mg SC every 2 weeks <input type="checkbox"/> Other: _____ <input type="checkbox"/> <u>Induction Dose</u> : Inject 160mg SC on day 1, then inject 80mg SC on day 15. <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 40mg SC once weekly <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 80mg SC every other week <input type="checkbox"/> Other: _____	3	0
<input type="checkbox"/> OTEZLA	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> <u>Titration</u> : Take 1 tablet by mouth at week 0 then increase as directed <input type="checkbox"/> Take 30mg by mouth twice daily	55	0

PRESCRIPTION SIGNATURE

Dispense as Written: _____ Substitution Permitted: _____ Date: _____

I Authorize Blue Sky Specialty Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process/appeals if necessary, in doing so, to release clinical information via phone/fax to appropriate third party payor.

Important Notice: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you have received this communication and you are not the intended recipient, you should not disseminate, distribute, or copy this fax. Please notify sender immediately if you have received in error and then destroy this document immediately.